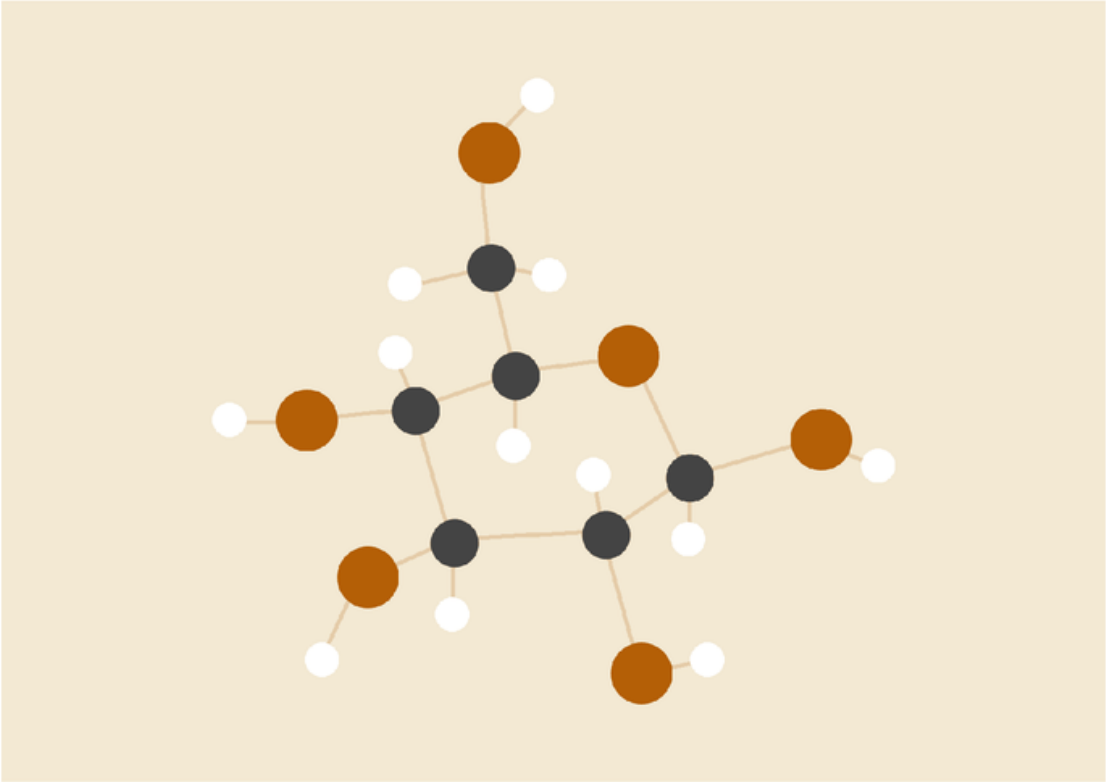
PPIP Assignment

by Paul Tudor Crowther

FILE	17994-1516_5580251_33409540_PPIP_ASSIGNMENT.DOCX (41.64K)		
TIME SUBMITTED	02-MAR-2016 08:46PM	WORD COUNT	3902
SUBMISSION ID	53674822	CHARACTER COUNT	21942

Personal, professional and interprofessional practice - preparation for registration portfolio (PIPP)

1. **3000 word reflective essay** demonstrating the application of professional, ethical and legal principles to one significant issue that a student has encountered in their current clinical practice



C3409540

2837 Words

Year 3 Mental Health Nursing.

Introduction

This reflection describes the professional, personal and ethical themes that resulted from a recent incident in practise. Included in the reflection are my personal thoughts and those discussed within the multidisciplinary care team (MDT) team, with my mentor and within a university syndicate discussion group.

This reflection encompasses my interprofessional learning (IPL) experience both in practise and with university colleagues as MDT work can be argued to improve the development of ideas and final decision making (Finkelman, 2006) and by embracing IPL I will be able to benefit from the perspectives of diverse professionals whose unique viewpoints may strengthen my ability to deliver improved health and social care outcomes (Sellman and Snelling, 2010, Thistlethwaite and Moran, 2010)

John's reflective model was selected for this reflection due to its structured approach and prompt questions which I found intuitive to follow and provoked reflection from different ethical, professional and personal perspectives. The greater context for reflecting on this incident is to develop professionally and frame my learning through experience into meaningful lessons that can better inform my future practice (Kolb, 2015), to examine through written analysis, wider contextual issues that arise from incidents (Griffin, 2003) and challenge care that falls short of the needs of patients and professional standards of my profession such as inadequate care that occurred in Mid-Staffordshire (Francis, 2013) and Winterborne (DH, 2012).

As per standards laid out in the NMC code of conduct, identifying features, including names and locations have been anonymised (NMC, 2015).

Description of the event

On placement in a mental health forensic inpatient unit. I worked with a patient named "Alan" whose relationship with a patient named "Martin" caused concern amongst staff. Previous incidents had included humour that had alluded to sexual exploitation of Alan by Martin whilst they were both in prison. Martin had brought drugs onto the ward and admitted to "sharing" these drugs with Alan. In prison Alan had been assaulted by inmates as a result of accumulated drug debts.

The incident that this reflection centres occurred shortly after Martin "shared" his drugs with Alan. Alan requested money from his patient account in order to purchase some takeaway food. Staff monitoring the delivery of takeaway and patient consumption observed that Alan had not received any food, Martin had received a large order of food despite not having ordered any. I discussed this with Alan who admitted that he had given away his food and the remainder of his money because he "owed a lot of money to someone".

The outcome from this incident was that Alan was deemed vulnerable, from financial or sexual exploitation and specifically at risk of physical violence due to presumed drug debts. An MDT decision was reached, which included advice from the local trust safeguarding team, the police, ward staff, hospital management and representatives from both patient's care team which included my mentor and myself. Due to the elevated risk of violence it was decided that Alan was to be transferred to another hospital. On police advice that advice surrounding Martin from a legal perspective was circumstantial, no action was taken further with Martin.

This reflection focuses specifically on the MDT decision to transfer Alan to another hospital.

Aesthetics

The specific remit of the ward where Alan was residing is the assessment and treatment of patients held under forensic section 3 of the Mental Health Act. Alan was in hospital under section 37 of the Mental Health Act (MHA, 1983) following a court

decision requesting hospital admission for assessment and treatment as opposed to a prison sentence. The final decision that Alan was assessed as unsafe to remain on the ward and that transfer to an alternative out of area forensic ward be better suited to his needs, could be argued as an effective outcome, based on better understanding of Alan's need to be protected from Martin. This section discusses the more complicated dilemma that was presented.

From a professional perspective it is a key standard of the Nursing and Midwifery Council's Code of Conduct (NMC, 2015) that confirms that nurses are to work collectively with other professionals to ensure the safety of patients receiving care, which is backed by Bowers et al and Seed et al who highlight the critical role of nursing staff in maintenance of patient safety (Seed et al, 2010, Bowers et al, 2011). Beyond the nursing specific responsibility to provide safe care (NMC, 2015), nurses operate under a professional mandate to ensure that vulnerable patients are protected (DH, 2011a, 2011b, 2011c). Nurses are also responsible for operating within the laws of the country in which they are practising (NMC, 2015) which means that they are responsible for upholding basic human rights for vulnerable patients (European Court of Human Rights, 2010) In the case of Alan, it is therefore arguable that Alan's care team were legally and professionally accountable for his basic safety above all matters including his assessment and treatment which matches the relative value of safety versus treatment or self-actualisation as discussed by Maslow in his pyramidal model of human needs where safety is accredited greater immediate priority than psychological wellbeing (Maslow, 1943).

To complicate matters, on an assessment and treatment unit healthcare staff have to balance the need for patient safety whilst respecting their autonomy (Department of Health (DH, 2007, RCP, 2008). By autonomy I refer to financial decisions making and independence (Rubin, 1998) and in regards to healthcare the self-determination of rights including treatment (Beauchamp & Childress, 2001). To reduce the potential for financial exploitation or in Alan's case drug debts the ward could have considered a heteronomous approach by restricting Alan's ability to access money and eliminating his financial autonomy. Such a risk averse approach would minimise financial exploitation,

one adverse risk that can be negated through management of autonomy (Robinson et al, 2007) but would also deny Alan the opportunity to take risks which are necessary in the improvement of quality of life to patients (Ramon, 2004).

Linked to this is the raison d'etre of the assessment and treatment unit which is to assess patients in their interactions with staff, patients, in activities which encompass different levels of engagement i.e from simple attendance such as attending mealtimes through to collaborative task planning and leave away from the ward. Managing small amounts of money is one of those positive risks and prior to staff intervention had been used for the purchase of takeaway food and toiletries. Limiting interactions with other patients and finances, would he depriving Alan from the opportunity of the full ward experience such as relationship building and peer support from fellow patient, therefore through being risk averse the ward is not allowing Alan to maximise the full potential of his life (Gallagher, 2013)

Prior to a MDT meeting I had a discussion with my mentor and described my thoughts that instead of a hospital transfer, Alan could potentially benefit from a discharge home on a Community Treatment Order, a compulsory treatment order where Alan would be under the supervision of a community based mental health care team, who would ensure Alan's engagement in treatment at home (Churchill, 2007) rather than an out of area hospital transfer. To my knowledge Alan met the criteria for a CTO and in my opinion it would be less restrictive than a transfer to another secure hospital meeting the Mental Health Act (MHA, 1983) requirement of operating with the least restrictive practice possible.

When the MDT meeting commenced it became apparent that between the clinical lead and Alan's psychiatrist the decision had already been reached to transfer Alan. An alternative CTO approach which was suggested by my mentor and argued by myself was dismissed without discussion. Other members of the MDT were present however were only invited to share ideas how to manage his care in the interim period prior to transfer. This approach to an MDT meeting appeared to exemplify poor communications between professionals which is argued to be a key component of effective MDT practice (Thistlethwaite & Moran, 2010). In hindsight I appreciate that the

decision making process may have been less inclusive of MDT perspectives in order to ensure safety for Alan, specifically the clinical lead and psychiatrist drove forward their planned course of action to minimise potential delays to the process by discussion by other involved professionals (Ellis & Hendry, 2011 & Finkelman, 2006).

Personal

I personally felt disappointed in that as a team I feel the decision to move Alan was a consequence of a number of preventable factors. Ward security was breached and despite Alan being in a secured ward environment had been able to purchase drugs and become indebted to another patient.

My personal view was that as a team by transferring Alan to another hospital we were in effect punishing the victim not the potential perpetrator of violence Martin. As documented above this situation does not have a true victim as Alan could be argued to have had capacity in the events leading to his transfer. However, from my perspective in this instance taking a decision founded on the ethical principle of justice (Beauchamp & Childress, 2001) specifically, that there was no direct evidence incriminating Martin and therefore no action could be taken against him. Through personal reflection I realised that this was a frustrating experience for me because having labelled Alan in the victim role and Martin in the bully role I was in danger of potentially over identifying with the victim due my childhood experiences of being bullied (Arnold & Boggs, 2003), which could have impaired my ability to acknowledge differences from my own personal experience. Through reflection and learning resulting from my communication skills in practice, I am aware that my professional and clinical identity is a composite of my life experience, personal values, norms, values, life events, vocational training, responsibilities and internal motives (Charlesworth, 2014), just as they are for both Alan and Martin. I am aware of what constitutes my own personal identity however, I should put aside preconceptions based on my life experiences and instead be aiming for the psychotherapeutic goal of “epoché” or looking at the world without preconceptions (Merleau-Ponty, 2002) to better understand Alan and Martin unique perspectives.

Discussion with my mentor reflected the fact that as team members we felt

disenfranchised and disempowered by the decision making process not fully including our views.

Ethics

Paramount to the decision to move Alan to an out of area hospital is the ethical decision making process that balances the need to protect his safety underpinned with the ideal of "Primum non nocere" or "first do no harm" (Smith, 2005) which recognises the potential for healthcare professionals to do harm as well as good through medical interventions. The reality is that the decision to move Alan to an out of area hospital is more nuanced, therefore is more akin to maximisation of positive health benefits via the ethical ideal of beneficence whilst understanding and minimising negative health outcomes by the ethical ideal of non-maleficence (Beauchamp & Childress, 2001). This section discusses the ethical dilemma in more detail.

To protect the safety of Alan a decision he was transferred out of area to another hospital which has ramifications for his treatment as highlighted by Pritlove and the Healthcare Commission who observed the need for patients to be treated in close proximity to their families, carers and community to improve treatment outcomes (Pritlove, 2012, Healthcare Commission, 2004, Edwards et al, 2012). In this case the ethics that reverberate around the decision to transfer Alan is the theoretical question of whether a transfer to another hospital to preserve short-term safety is worth the long term disruption to his care.

There are ethical considerations that extend beyond the ethical considerations for Alan. It cannot be ignored that the NHS is publicly funded, therefore expenditure is to be considered carefully, reflecting the view that ineffective use of public expenditure is deemed to be the result of organisational failure (Baxter et al, 2012). Therefore the question arises, was the transfer of Alan to an out of area hospital financially justified? Out of area hospital beds result in higher costs than a locally funded hospital beds

(Edwards et al, 2012) and result in Health Trusts wasting public money (RCP, 2010, Mountain et al, 2009) with subsequent personal and financial cost to families of patients (Mountain et al, 2009).

An important area to discuss is the ethical area of responsibility. The decision to protect Alan takes a paternalistic stance demarking the safety of Alan as the responsibility of the hospital. It could be argued that Alan is vulnerable at the risk of physical, financial and sexual abuse (DH, 2010) as a consequence of his own actions. Specifically Alan is held under section 37 of the Mental Health Act (MHA, 1983), however as capacity is made on an individual decision (MCA, 2005) it can be argued that he was capacious to make unwise decisions leading himself to being in a vulnerable position such as purchasing drugs from another patient for recreational use. Tests for capacity by the lead clinician had deemed Alan as having capacity for entering a upcoming court plea therefore he was able to retain information and weigh up the consequences of one course of action versus another.

As valid as these ethical debates are, healthcare staff are professionally obliged to follow security protocols to protect patients which overrides greater financial responsibilities to the public and the question of Alan's personal responsibility (NHS, 2010). This relational security advice states that in the case of victimisation of vulnerable patients staff are mandated to act before a serious incident happens. No specific course of action is expressly recommended nationally or in local authority literature leaving this to local interpretation, in this case a hospital transfer.

The clinical lead did not fully engage the MDT in the decision to transfer Alan and only included members in the team to facilitate Alan's safety prior to transfer. This course of action fits the profile of consequentialist/Machiavellian ethics (Machiavelli, 1998) of the result being more important than one's actions. If the MDT had preceded with a true open minded approach, ready to listen to team thoughts of potential CTO treatment options it could be argued that a more deontological approach was being engaged by the team, (Broad, 1930) specifically that the team was working with a process that was transparent and was prepared to accept the outcome of the process.

Empirics/Conclusion

The transfer of Alan to another hospital has resonated with me as the MDT management of the situation by the team was different to previous MDT experiences, specifically less inclusive of the views of all team members, instead in line with transactional leadership missives (Burns, 1978), with the objective established by senior figures without input from junior members of Alan's care team. The result of the failure to listen to members of the care team was a collective reduction in morale and team esteem, something I do not want to experience or perpetuate in future practice.

In the future I will be responsible for managing decisions regarding care of patients and there will likely be conflicting views of staff such as the case of Alan's transfer. In order for the optimum decision to be reached I would want to promote a culture of encouraging staff to contribute ideas based on evidence based practise (Barbuto, 2005 & Gheith, 2010) in line with values of transformational leadership (Burns, 1978), specifically to cultivate a work environment that harnesses creativity and innovation through empowering staff (Porter-O'Grady, 1997) which in the case of Alan's transfer would have started with improved MDT communication and where responsibility for decision making can be shared (Ward, 2002 & Bally, 2007).

Feedback from university colleagues, my mentor and colleagues on placement enabled me to gain perspective on the wider issues that the decision to transfer Alan caused. Gaining support and supervision to help frame and increase my understanding of nursing practice is a course of action I will continue to embrace as per advised practice (Christensen, 2009, Gilfedder et al, 2010)

I will continue to use reflective practise as part of Continuous Professional Development (CPD) to look at the wider context of any ethical, professional and personal perspectives that are relevant to future ethical incidents. The motivation behind this is more than recognition new revalidation practices for nurses but the overall

understanding that in future nursing roles I will be presented with barriers to ethical practice such as finite resourcing, time management and staffing levels (Ham, 2004, Torjuul & Sorlie, 2006), combined with evidence that cultural assimilation occurs where graduate nurses begin a career with a strong individual code of ethics which is eroded by the pressure to conform (Ham, 2004, Kelly, 1998). My opinion for the best treatment for Alan did not conform to the final decision held by senior management. The day that all my actions merely conform is a day that I will need to consider whether I am compatible with a field of care that lives and breathes in a complex ethical, professional and legal landscape.

REFERENCES

Arnold E & Boggs K. (2003). *Interpersonal Relationships: Professional Communication for Nurses, 4th edn*. Missouri: Saunders.

Bally J. (2007). The role of nursing leadership in creating a mentoring culture in acute care environments. *Nursing Economics* 25(3): 143–8

Barbuto J. (2005). Motivation and transactional, charismatic and transformational leadership: a test of antecedents. *Journal Leadership Organisational Studies* 11(4): 26–40

Baxter J, Fischer M & Malby R. (2012). *National Inquiry into Organisational Ethical Decision Making in the NHS – Full Report*. Available: http://www.idea.leeds.ac.uk/wp-content/uploads/2012/02/Ethics-Inquiry-full-report.pdf. Last accessed 1st March 2016.

Beauchamp T & Childress J. (2001). *Principles of Biomedical Ethics*. Oxford University Press, Oxford, UK.

Bowers L Dack C, Gul N, Thomas B & James K (2011). Learning from prevented suicide in psychiatric inpatient care: an analysis of data from the National Patient Safety Agency.

International Journal of Nursing Studies 48, 1459–1465.

Broad C (1930). *Five types of ethical theory*. London: Kegan Paul.

Burns J. (1978). *Leadership*. New York: Harper & Row.

Charlesworth B & Nicholson P. (2014). *The Therapeutic Relationship Handbook: Theory & Practice.* Eds: Charura, D. & Paul, S. Open University Press. Maidenhead. Forthcoming

Christensen M. (2009). Advancing practice in critical care: A model of knowledge integration. *British Association of Critical Care Nurses*, 14(2), 86–94.

Churchill R, Owen G, Singh S, Hotopf M. International experiences of using community treatment orders. London (GB): Institute of Psychiatry; 2007.

Department of Health. (DH) (2007). *Best Practice in Managing Risk*. DH, London.

Department of Health. (DH) (2010). *Clinical Governance and Adult Safeguarding: An Integrated Process.* The Stationery Office, London.

Department of Health. (DH) (2011a). *Safeguarding Adults: The Role of Health Service Practitioners*. The Stationery Office, London.

Department of Health. (DH) (2011b). *Safeguarding Adults: The Role of Health Service Managers and Their Boards.* The Stationery Office, London.

Department of Health. (DH) (2011c). *Safeguarding Adults: The Role of NHS Commissioners*. The Stationery Office, London.

Department of Health (DH). (2012). *Transforming care: A national response to Winterbourne View Hospital* . Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf. Last accessed 1st March 2016.

Edwards T, Wolfson P & Killaspy H. (2012). *A guide to good practice in the use of out-of-area placements.* Available: http://www.rcpsych.ac.uk/pdf/FR%20RS%2006_for%20web.pdf. Last

accessed 1st March 2016.

Ellis P & Hendry B. (2011). Too many cooks: has the teams approach in hospitals gone too far? *Journal of renal nursing;* May (3), 138-142.

European Court of Human Rights. (2010). *The European Convention on Human Rights: Convention for the Protection of Human Rights and Fundamental Freedoms.* European Court of Human Rights, Council of Europe, France.

Finkelman A. (2006). *Leadership and Management in Nursing.* Prentice Hall, Upper Saddle River, New Jersey.

Francis R. (2013). *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry: The Executive Summary,* London, The Stationery Office.

Gallagher A. (2013). Risk assessment: enabler or barrier? *British Journal of Occupational Therapy*; 76(7), 337-339.

Gheith N. (2010). Reconstructing organization culture through enforcing head nurses' transformational leadership style. *Australian Journal Basic Applied Sciences* 4(6): 1288–1296

Gilfedder M, Barron D, & Docherty E. (2010). Developing the role of advanced nurse practitioners in mental health. *Nursing Standard*, 24(30), 35–40.

Griffin M. (2003). Using critical incidents to promote and assess reflective thinking in preservice teachers. *Reflective Practice*, 4 (2), 207-220.

Ham K. (2004). Principled thinking: a comparison of nursing students and experienced nurses. *The Journal of Continuing Education in Nursing,* 35, 66–73.

Healthcare Commission. (2004). *Ratings 2004: Out of catchment area treatments (adults).* London: Healthcare Commission

HM Government. (2005). *Mental Capacity Act 2005*. London: OPSI.

Her Majesty's Stationery Office. (1983). *Mental Health Act (MHA), Chapter 20, Part III.* Available: http://www.legislation.gov.uk/ukpga/1983/20/section/37 Last accessed 29th Feb 2016.

Johns C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing *Journal of Advanced Nursing* 22 (2), 226-234.

Kelly B. (1998). Preserving moral integrity: a follow-up study with new graduate nurses. *Journal of Advanced Nursing* 28, 1134–1145.

Kolb D. (2015). *Experiential learning : Experience as the source of learning and development*. 2nd ed. New Jersey: Pearson.

Machiavelli N. (1998). *The prince (translation: Bull G)*. Penguin Classics, London

Maslow A. (1943). A theory of human motivation. *Psychological Review*. July, 370-396.

Merleau-Ponty, M. (2002). *Phenomenology of perception*. London: Routledge.

Mountain D, Killaspy H & Holloway F. (2009). Mental health rehabilitation services in the UK in 2007, *Psychiatric Bulletin,* 33 215-218,

NHS. (2010). *See, think, act - Your guide to Relational Security.* Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320249/See_Think_Act_2010.pdf. Last accessed 1st March 2016.

Nursing Midwifery Council. (NMC) . (2015). The Code. Professional standards of practice and behaviour for nurses and midwives. Available: http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revised-new-nmc-code.pdf. Last accessed 29th February 2016.

Pritlove J. (2012). Out of area treatments in mental health: the Leeds experience. *Mental Health Today*, May/June, 19-21.

Ramon S. (2004). *Approaches to risk in mental health. A multidisciplinary discourse. In: J. Tew,*

ed. Social perspectives in mental health: Developing social models to understand and work with mental distress. London: Jessica Kingsley.

Robinson L, Hutchings D, Corner L, Finch T, Hughes J, Brittain K & Bond J. (2007). Balancing rights and risks: Conflicting perspectives in the management of wandering in dementia. Health, *Risk & Society*, 9 (4), 389–406.

Royal College of Psychiatrists. (RCP). (2008). *Rethinking Risk to Others*. Royal College of Psychiatrists, London.

Royal College of Psychiatrists (RCP). (2010). *PCTs 'wasting millions' on out-of-area treatments, reveals RCPsych.* Available: http://www.rcpsych.ac.uk/press/pressreleases2010/oats.aspx. Last accessed 1st March 2016.

Rubin S. (1998). When Doctors Say No: The Battleground of Medical Futility. Indiana University Press, Bloomington.

Seed M, Torkelson D & Alnatour R. (2010). The role of the inpatient psychiatric nurse and its effect on job satisfaction. *Issues in Mental Health Nursing* 31, 160–170.

Smith C. (2005). Origin and Uses of Primum Non Nocere—Above All, Do No Harm!. *Journal Clinical Pharmacology;* 45 (4), 371-377.

Thistlethwaite J, Moran M. (2005). World Health Organization Study Group on Interprofessional Education and Collaborative Practice (2010) Learning outcomes for inter-professional education (IPE): Literature review and synthesis. *Journal Interprofessional Care* 24: 503-13.

Torjuul K. & Sorlie V. (2006) Nursing is different than medicine: ethical difficulties in the process of care in surgical units. Journal of Advanced Nursing 56, 404–413.

Ward K. (2002) A vision for tomorrow: transformational nursing leaders. *Nursing Outlook* 50(3): 121–6